North Carolina Department of Health and Human Services
Michael F. Easley, Governor
Dempsey Benton, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011• Fax 919-508-0951
Michael S. Lancaster, M.D. and
Leza Wainwright, Directors

Division of Medical Assistance
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-855-4100 • Fax 919-733-6608
William W. Lawrence, Jr., MD, Acting Director

August 4, 2008

MEMORANDUM

TO: Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: William W. Lawrence, Jr., MD
Leza Wainwright

SUBJECT: Implementation Update #47
CS Legislative Changes Clarification
Contact Information for VO
Authorizations for TFC
State Funded Services Contract
MOA Clarification

Clarification to Implementation Update # 46 Highlights: Community Support Service Legislation Changes
Special Implementation Update #46 was published on July 18, 2008 highlighting information related to legislation enacted through House Bill 2436, the Appropriations Act of 2008. The information provided in that update was a brief overview of specific items from Section 10.15A, Improve and Strengthen Fiscal Oversight of Community Support Services that required immediate action. The following is further clarification on some of those points.

Accreditation Benchmarks
Section 10.15A.(c) establishes a new statute, 122C-81 (see attached), which identifies accreditation benchmarks for providers enrolled with the Medicaid program or contracting for state-funded services through Local Management Entities to provide Community Intervention Services requiring national accreditation. Please note that the statute has two parts: it 1) establishes benchmarks that must be met for all providers subject to national accreditation requirements who enrolled with the Division of Medical Assistance (DMA) or contracted for state-funded services prior to July 1, 2008 and 2) reduces the time in which providers enrolling after July 1, 2008 have to achieve national accreditation from three years to one year and establishes benchmarks those providers must achieve within that year.

Providers who enrolled between March 20, 2006 and April 30, 2006, are now subject to the first benchmark. Any provider that enrolled during this time period that has not made a formal selection of an accrediting agency as documented by a letter

from the accrediting body acknowledging the provider's selection of that accrediting body will have their Medicaid enrollment and/or state funded contracts terminated. Within four months the following actions will occur:

1. The Local Management Entity (LME) will identify the provider(s) which did not meet the benchmark and submit a Notice of Endorsement Action (NEA). The NEA will establish the effective date of the withdrawal action which will be no later than four months from the date when the provider did not meet the nine-month benchmark.
2. No new consumers may be admitted by the provider agency.
3. Providers must work with the LME to transfer the entire caseload served by the provider over a four-month period, in increments of at least 25% per month. Please note that the Records Management and Documentation Manual, which applies to Medicaid and state-funded services, requires providers to copy and provide to the new provider on a timely basis relevant clinical and consumer-specific information to ensure continuity of care. It is the responsibility of the LME to identify other providers to serve the consumers impacted by the accreditation action. The consumer has a choice of the providers identified by the LME. Any provider utilized for transition must be a provider who is in substantial compliance with the rules and regulations of the Department of Health and Human Services (DHHS) and the MOA, including meeting all applicable accreditation benchmarks.
4. The LME will make readily available to the public a list of providers that will be terminated as a result of failure to achieve satisfactory progress in gaining national accreditation and a list of providers available to provide services to consumers impacted by the pending termination.
5. The LME is required to monitor paid claims to ensure caseloads are transferred within the four month timeframe.

During this transition period, the provider receiving consumers should ensure that a clinical review of the assessment and Person Centered Plan for each consumer is completed. The LME should work with the provider to transfer authorizations for state-funded consumers or assisting in coordinating with DHHS and ValueOptions to ensure a seamless transition.

These timeframes apply only to Accreditation Benchmark 1 (Nine Months). Subsequent benchmarks are at six months, three months, and the accreditation deadline. The actions that will be taken by the LME and by providers failing to meet the subsequent benchmarks will be similar but modified to reflect the different timeframes outlined in statute for those benchmarks.

Please note: A termination of a contract or Medicaid enrollment as a result of failure to meet a national accreditation benchmark is not appealable since these benchmarks are now the law in North Carolina. Please also note that the specific benchmark requirements are also in law. For example, to meet the first benchmark, the provider must not only have applied for national accreditation with an organization approved by DHHS by the date specified in the benchmark , they must have received a letter from the accrediting body acknowledging that selection by the date specified in the benchmark.

Community Support Increase of Qualified Professional Time
Section 10.15A.(i) requires that upon the Centers for Medicare and Medicaid Services (CMS) approval of the June 30th Community Support State Plan Amendment (SPA) which implements tiered rates that not less than 50% of all Community Support services will be required to be delivered by Qualified Professionals (QP). The 50% requirement was amended in the Technical Corrections Bill to the Budget (H2438), Section 3.11, which now requires 35% QP time sixty days after tiered rates are implemented and 50% QP time six months thereafter. Thus providers will have eight months after the implementation of tiered rates to get to the 50% standard. The 35% and subsequent 50% will replace the current 25% in the existing service definition, thus the same monitoring guidelines originally outlined for the 25% QP time will be applicable in the aggregate per site and service type for the 35% and 50% requirements.

Community Support 8 Hour Benefit Limit
Section 10.15A.(j) requires DHHS to adopt policy which reduces the maximum allowable hours of Community Support services to eight hours per week. The change was effective August 1, 2008. To provide further clarification on the processing of authorizations please note that for **new** requests adults may not receive over eight hours per week. For children under age 21, they may receive over eight hours BUT ValueOptions will require additional clinical justification as it is considered an Early Periodic Screening, Diagnostic and Treatment (EPSDT) review and must meet those requirements.

For **existing** authorizations the current level of authorization is maintained until the **authorization date expires** or **the existing units are exhausted** or **the condition changes.** At the time of a reauthorization adults may not receive more than eight hours but children may be eligible under the same conditions listed above. It should also be noted that although there is an existing medical order the new benefit limit restricts the order to what is available to the consumer to eight hours. This change in policy acts similarly to personal insurance - if a doctor orders a service but the insurance company denies it because it isn't covered by the policy the order remains valid, but no service is provided as the policy does not allow for it. However, in instances where it is thought that eight hours of Community Support is not adequate to meet the consumer's needs the provider should explore if another service is warranted and follow up with referrals as applicable.

Contact Information for ValueOptions and How to Escalate an Inquiry

An exciting new feature is being introduced as of August 8, 2008. In addition to being able to check authorization status and submit certain requests to ValueOptions' ProviderConnect, providers may now submit consumer specific customer service inquiries to ProviderConnect. Use of ProviderConnect to submit an inquiry adds another convenient and efficient method to contact ValueOptions. When ProviderConnect is accessed all inquiries receive an electronic response. Providers can use Your Message Center on ProviderConnect 24/7 for submitting inquiries. They may also continue to contact ValueOptions Customer Service for routine inquiries at 888-510-1150 between the hours of 8:00 a.m. and 6:00 p.m.

For requests to research multiple authorizations, providers may use the template found on the ValueOptions.com website. The link to download the template is at the bottom of the web page found by going to ValueOptions.com > Providers > Network Specific > North Carolina Medicaid. Providers should e-mail the request to Customer Service at PSDCustomerService@valueoptions.com as a password protected file per the instructions on the template.

Regarding inquiry escalation, a provider not satisfied with a response to, or the handling of, an inquiry should gather the pertinent information, call Customer Service, and simply ask to speak to a Customer Services supervisor to resolve the issue.

Authorizations for Therapeutic Foster Care

ValueOptions' long-standing practice is to send authorization and denial letters for therapeutic foster care to the LME that corresponds to the county code of the consumer's eligibility in effect on the date of the review. ValueOptions has added the name of the authorized LME to the list of authorization details telephoned to case managers upon an approval or denial of Therapeutic Foster Care (TFC). Note that the applicable LME receives an authorization letter and may access a copy of the TFC authorization letter via ProviderConnect.

State Funded Services Contract

DMH/DD/SAS, LMEs and providers have worked to make modifications to the standardized state-funded services contract. Since the contract had not cleared all review channels in time for a July 1 implementation date, LMEs were instructed to extend the SFY 2008 contracts for ninety days. The legal review is taking much longer than we had anticipated due to other pressing priorities and it appears unlikely that it will be available prior to the expiration of those extensions. In order to finalize this issue for this fiscal year, we are now instructing all LMEs to continue to use the standardized contract that was in place for SFY 2008 during all of SFY 2009. We will issue the revised contract as soon as it has gone through the entire review process to be effective July 1, 2009,

MOA Clarification

There has been some confusion regarding when an MOA is required in the absence of an endorsement. A MOA is required when an endorsed provider from one LME catchment area serves a consumer living in another county (where the provider has no site) outside the LME catchment area. For example, Provider A is endorsed by Durham LME, but a consumer residing in Chatham County requests services, Provider A is required by the endorsement policy to have an MOA with OPC LME. However, an MOA is not required by policy when a Medicaid consumer moves from the Medicaid county of origin and is now living in a county where the provider is endorsed. The Medicaid county of origin cannot require that an MOA be signed by the provider. In the above example, if the consumer from Chatham County moves to Durham County and requests services from Provider A in Durham County, Provider A is not required to have an MOA with OPC LME.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

cc: Secretary Dempsey Benton
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors
Christina Carter
Sharnese Ransome
Kaye Holder
Wayne Williams
Shawn Parker
Andrea Poole
Mark Van Sciver
Brad Deen

Attachment

"§ 122C-81. National accreditation benchmarks.

(a) As used in this section, the term:

(1) 'National accreditation' applies to accreditation by an entity approved by the Secretary that accredits mental health, developmental disabilities, and substance abuse services.

(2) 'Provider' applies to only those providers of services, including facilities, requiring national accreditation, which services are designated by the Secretary pursuant to subsection (b) of this section.

(b) The Secretary, through the Medicaid State Plan, Medicaid waiver, or rules adopted by the Secretary, shall designate the mental health, developmental disabilities, and substance abuse services that require national accreditation.

(c) Providers enrolled with the Medicaid program prior to July 1, 2008, and providing services that require national accreditation approved by the Secretary pursuant to subsection (b) of this section, shall successfully complete national accreditation requirements within three years of enrollment with the Medicaid program. Providers shall meet the following benchmarks to ensure continuity of care for consumers in the event the provider does not make sufficient progress in achieving national accreditation in a timely manner:

(1) Nine months prior to the accreditation deadline – Formal selection of an accrediting agency as documented by a letter from the agency to the provider acknowledging the provider's selection of that accrediting agency. A provider failing to meet this benchmark shall be prohibited from admitting new clients to service. If a provider fails to meet this benchmark, then the LMEs shall work with the provider to transfer all the provider's entire case load to another provider within four months of the date of the provider's failure to meet the benchmark. The transfer of the case load shall be in increments such that not fewer than twenty-five percent (25%) of the provider's total caseload shall be transferred per month. The Department shall terminate the provider's enrollment in the Medicaid program within four months of the provider's failure to meet the benchmark.

(2) Six months prior to the accreditation deadline – An on-site accreditation review scheduled by the accrediting agency as documented by a letter from the agency to the facility. A provider failing to meet this benchmark will be prohibited from admitting new clients to service. If a provider fails to meet this benchmark, then the LMEs shall work with the provider to transfer the provider's entire case load to another provider within three months of the date of the provider's failure to meet the benchmark. The transfer of the case load shall be in increments such that not fewer than thirty-three percent (33%) of the provider's total caseload shall be transferred per month. The Department shall terminate the provider's enrollment in the Medicaid program within three months of the provider's failure to meet the benchmark.

(3) Three months prior to the accreditation deadline – Completion of an on-site accreditation review, receipt of initial feedback from accrediting agency, and submission of a Plan of Correction for any deficiencies noted by the accrediting agency. A provider failing to meet this benchmark shall be prohibited from admitting new clients to service. If a provider fails to meet this benchmark, then the LMEs shall work with the provider to transfer the provider's entire case load to another provider within two months of the date of the provider's failure to meet the benchmark. The transfer of the case load shall be in increments such that not fewer than fifty percent (50%) of the provider's total caseload shall be transferred per month. The Department shall terminate the provider's enrollment in the Medicaid program within two months of the provider's failure to meet the benchmark.

(4) Accreditation deadline – Approval as fully accredited by the national accrediting agency. A provider failing to meet this requirement shall be prohibited from admitting new clients to service. The LMEs will work with a provider failing to meet this deadline to transition clients currently receiving service to other providers within 60 days. The Department shall terminate the provider's enrollment in the Medicaid program within 60 days of the provider's failure to meet the benchmark.

(5) A provider that has its enrollment terminated in the Medicaid program as a result of failure to meet benchmarks for national accreditation or failure to continue to be nationally accredited may not apply for re-enrollment in the Medicaid program for at least one year following its enrollment termination.

(d) Providers enrolled in the Medicaid program or contracting for State-funded services on or after July 1, 2008, and providing services which require national accreditation shall successfully complete all accreditation requirements and be awarded national accreditation within one year of enrollment in the Medicaid program or within two years following the provider's first contract to deliver a State-funded service requiring national accreditation. Providers providing services that require national accreditation shall be required to discontinue service delivery and shall have their Medicaid enrollment and any service contracts terminated if they do not meet the following benchmarks for demonstrating sufficient progress in achieving national accreditation following the date of enrollment in the Medicaid program or initial contract for State-funded services:

(1) Three months – On-site accreditation review scheduled by accrediting agency as documented by a letter from the agency to the provider and completion of self-study and self-evaluation protocols distributed by the selected accrediting agency.

(2) Six months – On-site accreditation review scheduled by accrediting agency as documented by a letter from the agency to the provider.

(3) Nine months – Completion of on-site accreditation review, receipt of initial feedback from accrediting agency, plan to address any deficiencies identified developed.

(4) If a provider's Medicaid enrollment or service delivery contracts are terminated as a result of failure to meet accreditation benchmarks or failure to continue to be nationally accredited, the provider will work with the LME to transition consumers served by the provider to other service providers in an orderly fashion within 60 days of notification by the LME of such failure.

(5) A provider that has its Medicaid enrollment or service delivery contracts terminated as a result of failure to meet accreditation benchmarks or failure to continue to be nationally accredited may not reapply for enrollment in the Medicaid program or enter into any new service delivery contracts for at least one year following enrollment or contract termination."